


Rev. 10/09

Attachment 3

Disclosure Statement

A criminal history background investigation is required by law (§ 37.2-416, *Code of Virginia*) on each individual who was not an employee or service provider at the facility prior to July 1, 1999. (Please type or print clearly.)

Licensed Provider Name	Provider Number (3 or 4 digit)
Levoc Family Services	1281
Applicant's Name (Last, First, Middle)	Social Security Number <input type="checkbox"/> No SSN #
Cradley, Cordie Dean	
Mailing Address (Street, City, State, Zip)	Phone Number (Area Code + Number)
In Virginia or any other location: Have you ever been or are the subject of a founded complaint of child abuse or neglect? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes: If yes, please list all cases and explain.	
Have you ever been convicted* of or are you the subject of pending charges for any offense, including moving traffic violations, but excluding offenses committed before your eighteenth birthday which were finally adjudicated in a juvenile court or under a youth offender law? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes: If yes, please list all cases and explain.	
<i>Convictions include all adult convictions as well as Virginia juvenile adjudication's for the following, Capital Murder, First and Second Degree Murder, Lynching, or Aggravated Malicious Wounding, if you were age fourteen (14) to eighteen (18) when charged.</i>	
*If convicted of misdemeanor assault & battery, please list date(s) of conviction(s). Were any of these convictions committed while employed in a direct consumer care position? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
I hereby certify that all entries on this disclosure statement are true and complete. I agree and understand that: (1) any falsification of the information provided, regardless of the time of discovery, may result in termination of my services as an employee; and (2) the information on this disclosure statement is subject to verification.	
 Signature of Applicant	3-6-12 Date

Original - DBHDS' BIU

Copy - Licensed Provider

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